TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PHYSICIANS MANAGEMENT SERVICES
DBA INJURY 1 TREATMENT CENTER

Respondent Name
XL SPECIALTY INSURANCE CO

MFDR Tracking Number
M4-13-3434-02

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 26, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Broadspire has not paid for the medical services for [injured employee] in accordance with applicable state law and regulations for the patient's Work Hardening Program... I am requesting Medical Dispute Resolution to help resolve this matter."

Amount in Dispute: $8,369.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is our position that this dispute falls out of the medical fee dispute resolution jurisdiction as it is a compensability issue and not a fee issue."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 16, 2013 through January 22, 2013	97545-WH-CA and 97546-WH-CA	$1,662.00	$1,631.00
January 23, 2013 through March 5, 2013	97545-WH-CA and 97546-WH-CA	$6,707.6	$0.00
TOTAL		$8,369.60	$1,631.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers' Compensation jurisdictional fee schedule adjustment.
   - 663 – Reimbursement has been calculated according to the state fee schedule guidelines.
   - 18 – Duplicate claim/services.
   - 886 – Reimbursement not recommended as service appears to be a duplicate of another service billed on the same date of service. $0.00.

Issues

1. Is the Requestor pursing dispute resolution for dates of service January 23, 2013 through March 5, 2013?
2. Did the insurance carrier appropriately raise the compensability issue(s) during the medical bill review process?
3. Did the Requestor bill for a CARF accredited Work Hardening Program?
4. Is the requestor entitled to reimbursement?

Findings

1. The Requestor contact, Kathy Gatewood, indicated that the requestor is no longer pursuing dispute resolution for dates of service January 23, 2013 through March 5, 2013 and continues to pursue dispute resolution for dates of service January 16, 2013 through January 22, 2013. As a result, the Division will only consider for review dates of service January 16, 2013 through January 22, 2013.

2. The insurance carrier denied the disputed services with claim adjustment reason codes, "W1 – Workers' Compensation jurisdictional fee schedule adjustment; 663 – Reimbursement has been calculated according to the state fee schedule guidelines; 18 – Duplicate claim/services; and 886 – Reimbursement not recommended as service appears to be a duplicate of another service billed on the same date of service. $0.00."

   Extent-of-injury and related disputes are decided through the Tex. Lab. Code Chapter 410 and 28 Tex. Admin. Code Chapters 140 through 144 dispute resolution processes. To determine whether such an extent-of-injury or related dispute existed at the time any particular medical fee dispute was filed with the Division and whether it was related to the same service, the applicable former version of 28 Tex. Admin. Code §133.240(e), (e) (1), (2) (C), and (g) addressed actions that the insurance carrier was required to take, during the medical bill review process, when the insurance carrier determined that the medical service was not related to the compensable injury: 31 TexReg 3544, 3558 (April 28, 2006). Those provisions, in pertinent parts, specified Former 133.240(e), (e)(1), (2)(C), and (g): The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division .... The explanation of benefits shall be sent to: (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and (2) the injured employee when payment is denied because the health care was ... (C) unrelated to the compensable injury, in accordance with § 124.2 of this title ,... (g) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code § 409.021, and § 124.2 and 124.3 of this title ... if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that:. . (3) the condition for which the health care was provided was not related to the compensable injury.

   Review of the submitted documentation does not support that the insurance carrier denied/reduced the disputed services for compensability, extent of injury and or liability issues during the medical bill review process. As a result, the new issue raised by the insurance carrier in their position summary is not supported. MFDR will therefore, proceed with the audit and only consider the denial reason(s) raised by the insurance carrier during the medical bill review process.

3. 28 Texas Administrative Code §134.204 (h)(1) states, "The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier. (1) Accreditation by the CARF is recommended, but not required. (A) If the program is CARF accredited, modifier 'CA' shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR. (B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

   28 Texas Administrative Code §134.204 (h)(3) states, "For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening. (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier 'WH.' Each additional hour shall be billed using CPT Code 97546 with modifier 'WH.' CARF accredited Programs shall add 'CA' as a second modifier. (B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes."

Review of the CMS-1500's documents that the requestor billed CPT Code 97545-WH and 97546-WH and appended modifier –CA to identify a CARF accredited work hardening program. As a result, reimbursement is calculated per 28 Texas Administrative Code §134.204 (h) (3) (B).

Review of the CMS-1500's document that the requestor billed 2 hours of CPT Code 97545-WH and 5 hours of CPT Code 97546-WH for dates of service 1/16/2013, 1/18/2013, 1/21/2013 and 1/22/2013. Review of the supporting documentation finds that the requestor seeks reimbursement in the amount of $415.50 for 7 hours of a CARF accredited Work Hardening Program rendered on January 16, 2013, January 18, 2013, January 21, 2013 and January 22, 2013. The requestor documented the following hours for each disputed date of service:

January 16, 2013, 7 hours documented. The Requestor seeks $415.50; the MAR amount is $448.00. The Requestor is therefore entitled to reimbursement in the amount of $415.50.

January 18, 2013, 6.15 hours documented. The Requestor seeks $415.50; the MAR amount is $400.00. The Requestor is therefore entitled to reimbursement in the amount of $400.00.

January 21, 2013, 6.15 hours documented. The Requestor seeks $415.50; the MAR amount is $400.00. The Requestor is therefore entitled to reimbursement in the amount of $400.00.

January 22, 2013, 6.30 hours documented. The Requestor seeks $415.50; the MAR amount is $416.00. The Requestor is therefore entitled to reimbursement in the amount of $415.50.

4. Review of the submitted documentation find that the requestor is entitled to a total MAR amount of $1,631.00 for disputed dates of service or the disputed services January 16, 2013 through January 22, 2013. As a result, $1,631.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,631.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,631.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 30, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.